

REFERRAL FOR BUREAU FOR THE BLIND SERVICES

Instructions: Complete and sign form. Completion of this form is voluntary.
Return to address below.

FROM: (Health Care Professional)		TO: (Bureau for the Blind)	
		Fax Number	
Name - Client (Last, First, Middle)		Birthdate (mm/dd/yyyy)	
Mailing Address		City	County
Telephone Number (Include Area Code)		Date - Last Examination (mm/dd/yyyy)	
ACUITY with best correction (Snellen Notation)	Right Eye	Left Eye	
FIELD in degrees (if available)	Right Eye	Left Eye	
Diagnosis			Age at Onset
Prognosis			
<input type="checkbox"/> Yes <input type="checkbox"/> No Is this person legally blind?			
Other Disabilities - Specify.			
Remarks (Use additional sheet if needed)			
SIGNATURE - Certifying Authority			Date Signed